

AFFIDAVIT OF LOST, DESTROYED, OR STOLEN CHECKS OR BENEFITS

AFFIDAVIT OF LOST, DESTROYED, OR STOLEN: <input type="checkbox"/> DEFRA Check Payment <input type="checkbox"/> Child Care Payment <input type="checkbox"/> Tax Intercept Payment <input type="checkbox"/> EOG/LOC Payment <input type="checkbox"/> WI Works (W-2) Payment <input type="checkbox"/> DVR Payment	Agency	Case or Provider Number (if applicable)	
	Payment Amount \$ _____	Payment Date \$ _____	Replacement Date
	Check Number (Missing Check)		Benefit/Issuance Number (If applicable)
1. Name (please print)		2. Telephone	
3. Current address		4. Date moved to this address	
5. Previous address (If you moved within the last month)		6. Date moved to this address	
7. Did you notify the agency of your move? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT APPLICABLE		8. Do you have a locked mailbox? <input type="checkbox"/> YES <input type="checkbox"/> NO	
AFFIDAVIT			
9. My payment or allotment is missing because: <input type="checkbox"/> It was not received through the mail. <input type="checkbox"/> It was received, but subsequently destroyed. <input type="checkbox"/> It was stolen from my mailbox. <input type="checkbox"/> It was stolen or extorted from <input type="checkbox"/> me, in person <input type="checkbox"/> a member of my family (name): _____ <input type="checkbox"/> Other (specify): _____ NOTE: If a witness was present, print witness' name, address and telephone in #11.			
10. (FOOD STAMPS ONLY) Envelope condition: <input type="checkbox"/> Good <input type="checkbox"/> Damaged <input type="checkbox"/> Sealed <input type="checkbox"/> Unsealed			
11. Was a witness present when the envelope was opened? <input type="checkbox"/> YES <input type="checkbox"/> NO If "Yes," print witness' name, address and telephone number:			
12. I certify, under penalty of criminal law, that neither I nor any member of my family (household) has received, directly or indirectly, or spent the payment or Food Stamp allotment described as missing above. I agree that if I find or subsequently receive the missing payment or allotment, I will return it to the agency. The information above is true and complete to the best of my knowledge. I understand that I may be subject to criminal penalties if any part of the above information is false.			
Signature of claimant/participant (or, for Food Stamps only , participant's representative)		Date	
Signature of witness		Date	
Witness' address			
Signature of agency/tribal representative (if applicable)		Date	

Re: 7 CFR 274 and Wisconsin Statutes § 16.41(1), 20.912(5)